COLORADO CENTER for
CLINICAL EXCELLENCE

Information and Disclosure Statement

1. Credentials: My name is **Laura Goldner, Psy.D.** and I am a licensed clinical psychologist (Colorado License Number 3233), holding the Doctor of Psychology (Psy.D.) degree in clinical psychology, conferred by the University of Denver's Graduate School of Professional Psychology. Licensure for Colorado psychologists requires 1500 hours of postdoctoral experience, 75 hours of supervision, and passing a national licensing exam.

2. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The **Board of Psychologist Examiners** can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-master's supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

3. Client Rights and important information:

(a) You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information. (b) You can seek a second opinion from another therapist or terminate therapy at any time. (c) In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant, or certificate holder.

(d) Generally speaking, the information provided by and to a client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in the Colorado statutes (section 12-43-218 in particular), in the Notice of Privacy Rights you were provided, and elsewhere in Colorado and Federal law. Some exceptions include threat of serious harm to self or others as in the case of suspected child abuse, suicide or homicide intent, or grave disability. Phone calls and other electronic communication are not secure. Also, you authorize with your signature below that in the event of my death or grave disability, one or more of my selected colleagues may review confidential information I have collected about you or your child in order to advise you of options for the continuity of treatment.
(e) My records regarding the treatment of adults will be kept for seven (7) years after treatment ends or following our last session, but may not be kept after seven years. My records for treatment of minors will be kept for seven (7) years, commencing on the last date of treatment or when the minor reaches 18 years of age, whichever comes later, but in no event am I required to keep these records for longer than 12 years.

I have read the preceding information and I understand my rights as a client or as the client's responsible party.

_____	_____	_____
Client's Name	Client's or Responsible Party's Signature	Date

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Fee Agreement

1. The Colorado Center for Clinical Excellence accepts direct payment for services, and will submit claims only for **Mines & Associates PPO** (for Ameriben/CU-GME and Rocky Mountain UFCW insured patients). We are not in-network for any other insurance company or administrator. Currently, many health insurance companies violate confidentiality and limit treatment to such an extent that we consider their practices and requirements too harmful for us to contract with them. If you are covered by Mines & Associates mental health benefits, please tell us. We will need you to complete our **Supplemental Fee Agreement for Insured Clients.** If you **have** Mines insurance, initial here____. If **not**, initial here____.

   If you plan to seek other insurance reimbursement after paying us directly, **please note** that we cannot guarantee they will reimburse you. You may not seek reimbursement from Medicare for our services (we have opted out of Medicare). If you receive Medicaid benefits, you may not seek services from non-Medicaid providers (we are non-Medicaid providers). Insurers require a psychiatric diagnosis to reimburse, and may require detailed clinical information from us. We are **not** willing to provide detailed clinical information beyond the basic information of diagnosis and attendance. We will not provide information about your behaviors, symptoms, risk factors, etc. Our unwillingness to provide detailed information **or other factors** may prevent you from being reimbursed. If you plan to seek reimbursement, **please determine in advance** what is required. Please note, psychiatric diagnoses may affect your ability to obtain future health, disability, or life insurance. More information is available online about privacy, risks, and insurance companies.

2. My standard fee is currently **$210.00** for a 50-minute session. My fee typically increases by $5 each January 1, so your fee would increase to **$215.00** per 50-minute session as of Jan 1, 2021. Payment is due at the time of the session by cash, check, or online through our ACH transfer or credit card processing platform. Phone sessions and extended sessions are billed on a per-minute basis.

3. While psychotherapy may vastly improve the quality of your life, it is also an expensive process. The duration of therapy is affected by the nature of your concerns and what your goals are. It is very important that you feel that you are benefiting from treatment. If at any time you feel that you are not getting what you want or need out of therapy, I urge you to discuss this with me so that we can find a solution for your concerns.

4. Appointment Cancellations: My fees are based on the time I commit to work with you in sessions. Any scheduled session not canceled 24 hours in advance is charged to you at the established fee.

5. Contract Agreement: *In signing this Fee Agreement, you agree that you have read and fully accept the terms contained herein. You are responsible for a fee of* ***$***_____ *. You agree that unless notified otherwise, fees increase by $5 each January 1.* Fees are due at the time of the scheduled session, unless other arrangements are made in advance. When you provide a check as payment, you authorize us (Jason A. Seidel, Psy.D. P.C. *dba* The Colorado Center) to (1) use information from your check to make a one-time electronic fund transfer from your account, (2) process the payment as an electronic check transaction, or (3) create and process a demand draft against your account. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment. If your payment is returned unpaid, you authorize The Colorado Center to represent the check either electronically or by a paper draft drawn on your account. You also agree to pay us a returned item fee of $20. By signing below, you also authorize The Colorado Center and its employees to release confidential information as may be required to pay a claim or to otherwise collect payment.

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Provider Date

1720 S. Bellaire Street, Suite 204 | Denver, Colorado 80222 | T/F: 303.547.3700
8000 E. Prentice Avenue, Suite D-12 | Greenwood Village, Colorado 80111 | T/F: 303.547.3700

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CONFIDENTIAL
Client Information

Name:_____ Gender: _____ Date _____

Address _____City _____ Zip _____

Phones: Home _____Work _____ Cell _____ Other _____

Okay to leave messages (e.g., for scheduling)? **Yes** **No** Which locations are okay?_____

How did you hear about us? _____ If referred, may I thank them for the referral? **Yes** **No**
(If so, no other information will be given to referral source without your permission, except that you came in for an initial visit.)

Age ____ Birthdate _____ List any siblings:_____ Race/Ethnicity _____ Sexual Orientation ____

Occupation _____ Any problems at work/school? _____

Education (*circle*): **Pre-HS** **Some HS** **HS Grad** **Some Coll** **Coll Grad** **Some Grad School** **Grad Degree**

Relationship status (*circle*): **Single** **Committed R'ship** **Married/Partnered** **Sep'd** **Divc'd** **Widowed**

Home environment (*circle*): **Alone** **With partner** **With roommate(s)** **With family member(s)**

Do you have children? **Y** **N** How many?____ Ages____ Add'l Details:_____

Please list names, ages, and relationship of all people in your household: _____

_____

Previous therapy? **Yes** **No** If so, when & with whom? _____

For what issue(s) did you go to get help? _____

What was helpful or unhelpful about it? _____

Are you eligible for Medicare? Y___ N___ **Medicaid?** Y___ N___

Please answer the following questions as openly as possible:

•What concerns bring you to therapy at this time? _____

_____

•When did these problems begin? _____

_____

•What have you been doing to cope with these problems? How successful has this been? _____

_____

•What do you hope to accomplish in therapy?_____

_____

•Please list all drugs (including medications) and alcohol you currently use, average amount per use, and frequency:

_____

•Please list any drugs you have recently stopped taking, and when: _____

•Any health concerns?_____

•Any current or anticipated legal problems? _____

•Any past or present suicidal thoughts or feelings? (Please describe) _____

_____

•Any recent or otherwise noteworthy losses (including miscarriages and abortions) for self or partner? _____

_____

•Any history of substance abuse by you or another family member? _____

•Any history of being hospitalized overnight for any reason? _____

•Any history of experiencing abuse (verbal, physical, sexual), assault, or neglect? _____

•Any history of head injuries or other noteworthy injuries? _____

•Do you have a spiritual affiliation or practice? Please describe: _____

_____

•Any eating concerns or problems with sleep?_____

•Additional concerns? _____

_____

•What will signify to you that you have gotten what you want from therapy? What will be better? _____

_____

_____

Thank You.
Please be sure to ask me any questions that you have about this form.

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Payment Set-Up
&
Unencrypted Texts & Emails

Unencrypted communication (through texts and emails) can be useful for appointment reminders, billing reminders, and such. However, **there is some level of risk that in an unencrypted email or text, a message can be read by someone else**. There is also risk that emails or texts may not "go through" to the recipient as intended. Do you want to receive unencrypted emails or texts from us (including replies to your texts or emails) about billing, appointment reminders, cancellations, etc.? (Please Note: Text and email is only for scheduling or billing purposes—not for clinical or personal matters. A reply may take 24 hours or longer.

☐ **YES**, understanding the risks, I agree to allow providers at The Colorado Center to send me unencrypted texts for scheduling and billing purposes.

My cell phone for texts is: _____

☐ **YES**, I agree to allow providers at The Colorado Center to send me unencrypted emails through its online appointment and billing services for scheduling and billing purposes. These invoices will include a diagnosis if I have asked for a diagnosis to be put on my invoices.

My email is: _____

☐ **NO**, I do NOT agree to allow The Colorado Center, or through its online appointment and billing services, to send me **ANY** unencrypted communications (including texts, emails, new payment information or invoices).

_____ _____ _____

Client's Name **Client's or Responsible Party's Signature** **Date**

If not the client, what is your name and relationship to the client? _____

☐ NEXT: Please go to http://thecoloradocenter.hint.com and provide your billing information on the secure signup page.

You will be asked to check two boxes: **The first checkbox** allows us to send unencrypted billing emails. The emails will come from "billing@thecoloradocenter.com". You can opt not to check this box. **The second checkbox** acknowledges that you have agreed to the 'member contract' which refers to these "intake" forms (information and disclosure statement, fee agreement, etc.). If you have any questions, please call me at 303-547-3700.

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Emergency Contact Form

We would like to have your emergency contact information on file in the unlikely event that it is needed. Please choose the situations in which you would be willing to have your therapist contact your emergency person.

Emergency Contact #1

_____ _____
Emergency Contact Name Relationship to You

_____ _____
Emergency Contact Phone Number Alternate Phone Number

Emergency Contact #2

_____ _____
Emergency Contact Name Relationship to You

_____ _____
Emergency Contact Phone Number Alternate Phone Number

I authorize _____ to call and/or leave a voicemail for the above emergency contact person, in the following circumstances:

☐ If I have a medical emergency while in the office for an appointment.

☐ If I have a psychological emergency (i.e., suicidal or homicidal thoughts). *Please be advised that—regardless of whether you check this box—your therapist will be required to take steps to maintain your safety and others' if he/she has reason to believe that you are an imminent danger to yourself or others. This may include contacting the police. This item indicates whether your therapist may <u>also</u> call your emergency contact.*

☐ If I am unable to be reached by phone or letter after a missed appointment.

_____
Client Name (please print)

_____ _____
Client Signature Date

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PLEASE READ OUR "NOTICE OF PRIVACY RIGHTS" DOCUMENT BY CLICKING HERE:
http://www.thecoloradocenter.com/CCCEnoticeofprivacyrights.pdf

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

Client:_____

I hereby acknowledge that I have received a copy of the Provider's Notice of Privacy Rights.

Signature:_____Date:_____

_____

If not the client, please print name and state legal authority to sign for client.

For Provider Use Only
The Provider's Notice of Privacy Rights was presented to the client or legal guardian today, but the client or legal guardian did not sign this acknowledgment because:

- ☐ The client refused to sign
- ☐ The legal guardian refused to sign
- ☐ The client was incapable of signing
- ☐ Other_____

Signature of the Provider:_____

Date:_____

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A Note about Our Approach to Therapy

I work with my clients in a **feedback-informed** way: We track how your well-being is changing as we work together, to help you get the most out of therapy.

In the forms attached to this sheet (or in the waiting room when you get here), I want to get a sense of how things have been going for you, and to see how these answers may change over time.

How does it work?

In most sessions, I will have you rate your well-being with just a few questions. I will show you an ongoing graph of how your experience is changing over time. We will be able to use this information to know if things are going in the right direction or if there is something else that we may want to address.

Occasionally, I may give you another form or two to get a fuller sense of how your well-being is changing. We can talk as much (or as little) about these forms as you want. I also look at trends in outcomes to see if there are areas I need to address to improve the quality of therapy I provide to my clients. The Colorado Center also uses the information—*removing any identifying information about individual clients*—to conduct research to improve feedback-informed treatment and methodologies.

The forms

Most sessions:

- The ROS: an ultra-brief measure of well-being (30 seconds)
- The SES: an ultra-brief measure of session quality (30 seconds)

Intermittently:

- Longer measures of well-being or session quality, such as the PRN (2 minutes) or HAq-II (2 minutes)

Confidentiality/Privacy:

Just like your other personal information, I keep your answers totally confidential. We disguise all data for our feedback analysis, research, and quality reporting. **No client names** are ever associated in any way with our outcomes analysis (please don't even write your name on the forms, but if you are here with someone else—such as a spouse—please put your first initial on your forms).

Your first session:

We give you a couple of forms about well-being at your first session (typically, the ROS and PRN), which will probably take you about 3 minutes to complete. **Please think about the reasons you are coming for therapy when answering them**. Toward the end of the session, we will give you three forms about how the session seemed to you. Unlike most feedback situations, we actually want the bad news, because that is how we can figure out how to improve what we are doing! If you have serious concerns about completing these, please let us know so we can address them. While this information can be very helpful to improve therapy quality, there are unusual situations in which a client requests that we not track progress this way. Please check this box: ☐ if this may be the case for you.

I understand and agree to participate in this collection and use of outcome/quality data.

_____ _____

Client or Guardian Signature Date

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